

Manual for psychiatric examination of non-adults

BASIC INFORMATION

Initials, age, nationality.
Route of referral.
Date of admission.
Date of examination.

HISTORY

Family history

Mother: name, age, education, actual occupation, diseases (actual somatic diseases, other diseases focusing on genetic, neurological and psychiatric diseases).

Father: name, age, actual occupation, diseases (actual somatic diseases, other diseases focusing on genetic, neurological and psychiatric diseases).

Brothers/sisters according to their age: name, age, education, actual school attended or actual occupation, diseases (actual somatic diseases, other diseases focusing on genetic, neurological and psychiatric diseases).

Presence of any psychiatric, genetic, neurological or major somatic disorders in the rest of the family.

Personal history

Information about prenatal circumstances of the patient: gravidity order, normal / high-risk pregnancy (reasons?). Information about delivery: birth in term / pre-term / post-term, gestational age as newborn infant, any complications or eventual resuscitation, Apgar score, birth weight and length.

Early psychomotor development, development of speech (any delays or problems?). The age of the beginning of attendance of kindergarten, description of adaptation (including information about relationships, separation from caretakers, preferred games, presence of rituals). The age of the beginning of attendance of elementary school, and description of adaptation. Education progress, grades, subjects of interest, relationships with other schoolmates / teachers. Description of any problems in school, including learning problems, individual school program, changing of school for any reasons, bullying.

Detailed chronological list of diseases, injuries, traumas (including head traumas), major surgery, epileptic seizures, states of unconsciousness and other somatic problems & nonpsychiatric hospitalizations or examinations at specialized professional since birth till present.

Social history

Name of institution and actual school year that the patient is currently attending (including the name of class teacher). Current grades at school. Description of the place where the patient is living most of the time (home / dormitory / orphanage / other institution – number of rooms in the apartment, number of roommates, any other significant information about the amount of freedom vs. surveillance of the patient). Financial situation of the patient's family. Relationships between family members and patient, including the relationship between parents. Previous and actual hobbies of the patient.

Allergies

Allergies to medication, food, dust, animals, trees, plants or anything else.

Medication history

Names, doses and frequency of current medication in the patient.

Psychiatric history

Information about previous psychological / behavioural problems or psychiatric examinations or hospitalizations (including names of specialists, dates, conclusions, diagnoses and prescribed medications).

Information about the use of addictive substances

Information about the first experience, amount and frequency of drinking coffee, alcohol, smoking cigarettes, experimenting or using other drugs, or other unhealthy habits.

Physiological functions

Information about possible problems with sleeping (length, interruptions, falling asleep, nightmares), eating (increased or decreased appetite, digestive problems, gaining or losing weight), urination, or stool.

PRESENTING COMPLAINS

Current problems

Description of the current problems for which the patient was admitted to hospital. For each individual problem record its chronology, onset (acute / progressive / chronic) and duration, severity, impact on functioning, associated symptoms and associated life events occurring around the same time. Note precipitating, worsening, and relieving factors; external conditions at the time of the onset. Have these or similar symptoms occurred before? Description of premorbid characteristics of the patient.

Documenting the patient's subjective report

Note verbatim statements of the patient using quotes, especially those including pathological content. This helps you to make a general picture of vocabulary, length and structure of sentences, type of information coming from the patient, as well as present pathology.

OBJECTIVE FINDINGS

Somatic examination

Complete somatic and basic neurological examination of the patient, including detailed description of findings on skin (including wounds, bruises, scars, drawings, piercings, tattoos).

Description of behaviour during examination

Objective description of the patient's appearance (hygiene status, clothes style, evidence of self-neglect or any other significant findings). Description of the patient's behaviour during the examination, their level of (in-)activity / violent behaviour during examination. Quality of contact (including eye contact). Description of the speech: volume and speed of speech, answers to questions – latencies, adequacy, quantity, spontaneity, pauses. Mimics and pantomimic showing emotions during the interview. Attitude of the patient toward examination and their cooperation.

Clinical symptomatology

Consciousness, orientation in time, place, personality and situation. Perception, the presence of nonverbal signs of perception problems. Actual state of mood, presence of intrapsychic tension or anxiety. Psychomotor speed, concentration, description of affectivity and emotivity, description of thinking focusing on coherency, speed, structure, contents, pathological contents (and whether the patient is egosyntonic or egodystonic with them), presence of suicidal ideas. Description of behaviour (taken from the patient's history), dispensation, socialization with other people, activities and interests. Description of feelings, self-assessment, suspected intellect. Description of personality, including reference to the component which is altered.

PSYCHOPATHOLOGICAL ANALYSIS

Summary of important information obtained from history and examination of patient, including any circumstances with possible influence on them. Comprehensive review of symptoms and signs (especially psychopathological findings). Differential diagnostic consideration of possible diagnosis and reasoning the supportive / contradictory findings for each considered diagnosis.

CONCLUSIONS

Syndromological diagnosis

Working clinical diagnosis

The most probable main diagnosis (even if not completely specified or narrowed yet), followed by the list of other psychiatric and somatic diagnoses.

Differential diagnosis: Other possible diagnoses responsible for the current hospitalization.

Diagnostic plan: Plan of further diagnostic procedures (during hospitalization).

Therapeutic plan: Plan of the patient's therapy during hospitalization (including psychotherapy, pharmacotherapy or any other therapy / rehabilitation procedure).